This form should be used to request outpatient treatment. Revised 10.6.21	COUNTY OF SAN DIEGO BEHAVIORAL HEALTH PLAN **OUTPATIENT AUTHORIZATION REQUEST** Please check: ☒ Initial Request ☐ Continuing Request **PLEASE SUBMIT DEMOGRAPHIC FORM W/ INITIAL REQUESTS**	To request authorizations, fax or mail to: Optum Public Sector Fax: (866) 220-4495, PO Box 601340 San Diego, CA 92160-1340 Phone: (800)798-2254, option 3 then 3

CONFIDENTIAL **Client Information** *CONFIDENTIAL*

Client Last Name: First: Middle:		Client Ethnicity:
Last Name, First Name Middle Name	Gender: ☒ M ☐ F ☐ O	Caucasian

Age:	DOB:		
47	05/18/1971	Living Situation: ☒ Homeless ☐ Alone ☐ ILF ☐ B&C ☐ SNF ☐Other, with whom? Click here to enter text.	Justice System Involvement: ☐ N/A ☒ Yes: Possession of elicit substance 8/2021 If Yes, explain: Arrested for possession. Pending court date.

Medi-Cal CIN #:	Highest Education Level:	Current Employment Status:
00000000F	High school graduate	unemployed
Current Health Plan: Care 1St	If Child, current IEP: ☐ Yes ☐ No School District:	San Diego Regional Center Client: ☐ Yes ☒ No

Current Referral by Child Welfare Services: ☐Yes ☒No:	If Yes, PSW name and number: N/A

If Hx of CWS, when and why? N/A

DSM IV/ICD 10 Diagnosis and Other Clinical or Medical Considerations

Primary Diagnosis Description: Schizoaffective Disorder, Bipolar Type	ICD 10 Code: F25.0

Other Diagnoses (Mental & Physical Health):
Other stimulant use, unspecified, Hypertension, Diabetes Type 2

Presenting Mental Health Problem, Symptoms, Functional Impairment

Current Symptoms (please list w/ frequency and duration):
Client symptoms include: Daily auditory/visual hallucinations, grandiose delusions, mood swings that vacillate between episodes of mania (approx. 1x mo.) and major depression (6/7 days a week), sudden increase in energy, hyperverbal, feelings of worthlessness and sadness. Client reports daily, intermittent, passive SI with no plan or intent. Client has history of 2 suicide attempts-one at age 16 via cutting and one at age 33 via OD on medications and was recently hospitalized for psychotic behaviors in August 2021. Client is non-compliant with psychotropic medications and lost housing at last sober living as a result of aggression toward peers and relapse.

How is the client significantly impaired in an important area of life functioning as a result of their symptoms or diagnosis? If client is a child, how is their development at risk of not progressing appropriately due to their symptoms or diagnosis:
Symptoms impact client's ability to obtain employment, maintain relationships and housing. Client uses stimulants to self-medicate and does not effectively manage medical issues due to symptoms.

Hx of Trauma and/or Abuse? ☒ Yes ☐ No	If Yes, explain: Client reported childhood physical abuse from step-father and multiple assaults while homeless.
Substance Use: ☐ N/A ☐ HX ☒ Current	Drug(s) of choice: Client reports current methamphetamine use approx. 1x a week

Describe current substance use impact on functioning:

Client lost his housing due to relapse at sober living and continues to use substances to manage mental health symptoms, though remains pre-contemplative regarding use and its impact.

Current Risk Assessment:						
	Suicidal -	☐ N/A	☒ Ideation	☐ Plan	☐ Intent	☒ History of harming self
	Homicidal -	☒ N/A	☐ Ideation	☐ Plan	☐ Intent	☐ History of harming others

Client Strengths (i.e., motivated, employed, strong social supports): Client is resourceful and able to identify triggers to substance use. He reports being committed to treatment "this time around" due to recent loss of housing.

Medications (Psychiatric, Medical, & OTC medications)

Name of Medication w/ Dosage or N/A:

Depakote 500 mg TID	Click here to enter text.	Click here to enter text.
Abilify 20 mg daily	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.

Treatment

Proposed Interventions (CBT, DBT, behavioral, strengths-based, groups, etc.): CBT, MI, and client-centered

If Group Therapy, # Participants: N/A Group Topic/Focus: N/A

Treatment plan with measurable/observable goals addressing diagnosis, functional impairments, and risk (include frequencies and duration of treatment goals and separate Individual and Group if facilitating both):
Goals include: maintain safety, secure housing, consistent medication management compliance, reduce substance use, develop safety plan, identify triggers to behaviors, implement coping skills in order to reduce risk for DTS/others, improve overall daily functioning and reduce Symptoms of depression, mania and psychosis.

-Reduce psychosis (AH/VH) and manic symptoms by 50%
-Maintain safety 100% of the time through development of safety plan and identifying triggers
-Learn and implement 3 coping skills to reduce symptoms and prevent relapse
-Link to housing and substance use referrals
-Plan to later incorporate potential trauma work and symptoms management after obtaining basic needs.

Current treatment provided by others and/or Hx (i.e., Psychiatrist, PCP, NP, CM, TBS, Substance Use Tx, Groups, Peer Support):
No current psychiatrist. History of Crisis House and Case Management, though no current services. PCP through local FQHC.

How have you coordinated with these providers? If not, please explain: Plan to coordinate with PCP to increase medical care compliance and refer to psychiatrist.

Progress: ☒N/A (Initial Request) ☐ Near completion ☐ Improving ☐ Stabilizing ☐ Regressed due to new stressor ☐ Little/no progress

Expected Length of Treatment: 6/12 months	If Initial Request, date of Assessment with you: 10/13/2021

Referrals made to other community supports and/or aftercare plans for client's recovery: Plan to provide linkage to psychiatrist and substance use referrals.

Client Signature

******I, (print name) Click here to* enter *text.participated in the development of this plan and received a copy.*

Client Signature: First Name Last Name *Date: 10/18/2021*

(Signed Client Plan required in Client's Chart within 30 days of commencing treatment; may use separate form than the OAR)

Provider Requested Authorization Units – Please Sign Below

On Begin Date of Sessions, Client is: ☐ Adult ☐ Child
Interpreter needed for these sessions: ☐No ☐Yes, Language: Click here to enter text.

Treatment	Begin Date of Sessions	# of Sessions	Frequency # Sessions per Wk/Mo/Yr	For Optum Care Advocate Sign Approved Service
Psychotherapy (max 12)	**10/13/2021**	**12**	**1x weekly**	
Group Psychotherapy (max 12, specify length of session)				
Team Conference (99366 or 99368)	**10/13/2021**	**4**	**2x weekly**	
Other:				
Other:				

Provider Information

Name/Licensure: Caring Provider, LMFT	Phone: 000-000-0000	
Provider Signature: Caring Provider, LMFT Date:10/13/2021	Fax: 000-000-0000	If Modified or Denied, Date of NOA: _____
If Group Practice, name of Group:		

For Optum Care Advocate

If Request Modified or Denied, below sessions were authorized:

Authorized Treatment	Begin Date of Auth	# of Sessions	Frequency	Optum Signature